HISTORY

(Last, First,, Middle) CLIENT NAME:		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

History of Present Illness (Include present signs and symptoms)

_____

_____

Past Medical History

Previous Diagnosis of TB (Check one) G Yes G No G Unknown
If Yes, Month/Year of Diagnosis: _____/_____
If more than one previous episode, check here: G

Previous Skin Test for TB (Check one) G Yes G No G Unknown
If Yes, Results: G + G - G Unknown
If Yes, Month/Year: _____/_____

BCG Vaccination (Check one) G Yes G No G Unknown
If Yes, Date: _____/_____/_____

Prior HIV Test (Check one) G Yes G No G Unknown
If Yes, Results: G + G - G Unknown
If Yes, Month/Year: _____/_____

Diabetes (Check one) G Yes G No G Unknown
If Yes, Insulin? G Yes G No

Hospitalized in Last Year (Check one) G Yes G No G Unknown
If Yes, Where/Why: (Limit 40 characters)_____

Current Tobacco Use (Check one) G Yes G No G Unknown
If Yes, Amount: _____(Check one below)
G Pk/Day G Pk/Wk G Pk/Mo
G Cig/Day G Cig/Wk G Cig/Mo

Silicosis (Check one) G Yes G No G Unknown

Leukemia/Lymphoma/Other Malignancies (Check one) G Yes G No G Unknown

Immunosuppressive Therapy (Check one) G Yes G No G Unknown

Gastrectomy/Internal Bypass (Check one) G Yes G No G Unknown

HISTORY

CLIENT NAME: (Last, First,, Middle)		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

Hepatitis (Check one) G Yes G No G Unknown

Kidney Failure (Check one) G Yes G No G Unknown

Pregnant Now (Check one) G Yes G No G Unknown

Is Client Taking any Medications that could interact with TB Medications (Check one) G Yes G No
If Yes, Specify:_____

Medication Allergies _____

Homeless within Past Year (Check one) G Yes G No G Unknown

Resident of Correctional Facility at Time of Diagnosis (Check one) G Yes G No G Unknown
If Yes, (Check one)

G Federal Prison G Juvenile Correctional Facility
G State Prison G Other Correctional Facility
G Local Jail G Unknown

Resident of Long-Term Care Facility at Time of Diagnosis (Check one) G Yes G No G Unknown
If Yes, (Check one)

G Nursing Home G Mental Health Residential Facility
G Hospital-Based Facility G Alcohol/Drug Treatment Facility
G Residential Facility G Other Long-Term Care Facility
G Unknown

Within the past 12 months, does client have a history of: (Check one)

Injected Drug Use G Yes G No G Unknown
Non-Injected Drug Use G Yes G No G Unknown
Excess Alcohol G Yes G No G Unknown

Occupation (Check all that apply within the past 24 months)

G Health Care Worker G Migratory Agricultural Worker
G Correctional Employee G Other: Specify _____
G Unknown G Not Employed in Past 24 Months

User Defined Variable Information: (If needed)

_____ ____/_____/____
Completed By Date